MDaudit

Annual Benchmark Report

Healthcare Billing Compliance, Coding, and Revenue Integrity

2022 EDITION

Contents

Summary

Introduction

> Two years into a global pandemic, amid sweeping inflation and prolonged staffing shortages, superlatives and words like “unprecedented” no longer seem adequate. It is, likewise, inadequate to simply call 2022 a disruptive year for healthcare organizations.

Though some expected 2022 to be the first year for post-COVID recovery, that has not proven to be the case. Health systems and hospitals have faced intense staff and resource pressures since the onset of the COVID-19 pandemic in 2020. Going into fall 2022, many now face a unique double whammy – both on supply and demand.

As consumers cut discretionary healthcare spending and postpone medical visits, our analysis shows patient volumes began falling dramatically in physician office visits and hospitals for the 3rd quarter relative to the first two quarters of 2022 – as steep as 33%. According to a report from Kaufman Hall on the current state of hospital finances, more than half of hospitals are projected to yield negative margins through 2022.

> More than half of hospitals are projected to yield negative margins through 2022.

The FY 2023 Department of Health and Human Services (HHS) budget signifies what lies ahead on the regulatory front. The HHS FY 2023 budget provides $2.5 billion in total mandatory and discretionary investments for the Healthcare Fraud and Abuse Control (HCFAC) and Medicaid Integrity Programs. The budget requests $899 million in discretionary HCFAC funding, $26 million above the FY 2022 enacted level.

Together, the Centers for Medicare & Medicaid Services (CMS), the Department of Justice (DOJ), and the HHS Office of Inspector General (OIG) are investing in predictive modeling and artificial intelligence tools to scrutinize claims more closely before adjudication, to reduce improper payments without adding administrative burden.

Against this macro-level backdrop, healthcare organizations have tremendous pressure to reduce compliance risk while optimizing revenue flow. This will require flawless optimization for billing compliance, coding, revenue cycle, and revenue integrity capabilities. Amidst the challenges, we find many opportunities for health systems to accelerate digital initiatives and drive sustainable value with analytics, automation, collaboration, and upskilling people.

Top Trends for 2022

- Defending revenue will be as critical to health systems as growing revenue in 2023. Profitability will depend on it, as Medicare-related audits and other risks ramp up exponentially.
- The role of billing compliance will continue to be increasingly data-driven and cross-functional, serving as a business partner to other teams, including coding, revenue integrity, finance, pharmacy, and clinical, to meet changing and more complex risks.
- On average, resolving accuracy issues in billing and coding operations can help retain 15%-25% of overall revenue.
- All payers are not equal. Organizations must monitor their payer mix and the unique risks associated with each. We see the greatest risks for organizations that are increasingly dependent on federal payers to carry a larger burden of proof for timely payments, administrative costs, and defending audits.

82% of denials in 2022 were associated with Medicare

according to analysis of MDaudit data for the top 10 payers across all customers

- Powerful technologies, including cloud, artificial intelligence (AI), machine learning (ML), and predictive analytics, will catalyze health systems to proactively monitor and quickly address compliance and revenue risks as they emerge.

Who is this report for?

- **CHIEF COMPLIANCE OFFICERS**
- **CHIEF FINANCIAL OFFICERS**
- **DIRECTOR OF PROFESSIONAL / HOSPITAL BILLING COMPLIANCE**
- **VP OR DIRECTOR OF HIM / CODING**
- **VP OR DIRECTOR OF REVENUE INTEGRITY**

Now, more than ever, everyone in the health system must concern themselves with growing and protecting revenues to ensure profitability. With industry insights, trends, and data, our annual MDaudit Benchmarking Report empowers compliance, HIM/coding, revenue integrity, and finance executives to identify risks and opportunities to drive action and improve outcomes within healthcare organizations.

Take Action with Executive Insights

Executive Insights for Billing Compliance

- **Focus on revenue retention.**
  In 2023, revenue retention will be as critical as revenue growth. Medicare-related audits will ramp up exponentially, creating added pressure for healthcare revenue streams.

  HHS has requested $900M for discretionary spending to advance technologies to scrutinize payment accuracy – part of a 10-year, $6.3B spend expected to yield double that in Medicare and Medicaid baseline savings.

Important Trends for Billing Compliance

USING DATA TO DRIVE SMARTER AUDITS

In 2022, more billing compliance teams are leaveraging data analytics to proactively identify and mitigate compliance risks.

Risk-based audits have increased by

28%

Prospective audits have increased by

31%

- **Be data-driven.**
  Due to the dynamic nature of emerging risks, billing compliance leaders must leverage data and analytics as a catalyst to proactively detect risks and perform audits for corrective action. Data-driven, risk-based audits can complement the annual compliance plan to ensure effective audit scope coverage.

  Across the MDaudit cohort, risk-based audits have increased by 28% in 2022 compared to last year.

- **Deploy a hybrid auditing strategy.**
  The industry has been debating retrospective vs. prospective auditing for almost a decade. MDaudit benchmarking data demonstrates that organizations deploying both auditing methods – where they learn from their retrospective audits and apply those insights to their prospective audits – are achieving better outcomes. When health systems are financially stretched, compliance teams can drive cross-functional initiatives that mitigate compliance and revenue risks.

  Across the cohort, prospective audits have increased by 31% in 2022 compared to last year.

- **Monitor compliance risks.**
  Overcoding remains pertinent in professional office visits. With upcoming changes in 2023, compliance teams should pay attention to the coding of E&M levels, as it drives reimbursement. In hospital billing, bundling is a major driver of compliance issues, followed by billing and coding errors.

  In 2022, overcoded charges reclaimed 21% of the revenue recovered from undercoded claims. Besides revenue, overcoding is a risk to hospital branding, reputation, and potential for regulatory fines.

- **Collaborate to accelerate outcomes.**
  To solve systemic challenges and drive outcomes with greater impact, billing compliance teams must partner with cross-functional peers from coding, revenue integrity, revenue cycle, clinical documentation integrity (CDI), IT, and others.

  The deployment of cloud-based technologies with integrated workflows and powerful analytics, driven from multiple sources of internal and external data (including billing, payment, auditing, market-level costs, and payer data), can enable collaboration and accelerate outcomes.

A SPECIAL FOCUS ON EXTERNAL AUDITS

Compliance teams should be efficient in managing external payer requests to retain at-risk revenues, with close attention paid to the below areas for overcoding, medical necessity, clinical documentation, and bundling-related issues. The implication of getting paid on time for these often-expensive services can significantly impact an organization's profitability and financial health.

Based on the analysis of MDaudit denials data and HHS/OIG updates, below are key external audit scope areas that drive substantial costs and resources out of our healthcare system.

Focus Areas for Outpatient Billing

- Surgeries that involve multiple services performed by the same surgeon and must be billed together
- Surgeries – orthopedic, spine, neurosurgery
- Specialty drugs and clinical justification for units administered for treatment
- Hospital observation care services
- Implants/medical devices
- Laboratory – chemistry, general classification, hematology, immunology, bacterial
- Telehealth

Focus Areas for Inpatient Billing

- Short stay inpatient
- Rehabilitation facilities
- DRGs that drive higher healthcare costs
- Sepsis
- Cardiology
- Digestive system
- Kidney

Medicaid Managed care plans with commercial payers are under constant scrutiny as OIG and CMS have ongoing concerns about managed care plans' efforts to combat fraud, including concerns about a lack of fraud referrals.

Executive Insights for Revenue Integrity

- **Pay attention to your payer mix.**
  Develop a revenue-risk view based on each payer's denial response. The staggeringly disproportionate number of denials associated with Medicare indicates that RI leaders should pay special attention to federal payers-related denials and audit requests.

  > *82% of denials in 2022 were from Medicare Part A and Part B, according to an analysis of MDaudit data for the top 10 payers across all customers.*

- **Avoid billing and coding errors.**
  Maximizing revenue retention may be complex, but something as simple as correctly coding and billing professional and hospital claims can make a significant difference.

  > *MDaudit analysis shows that, on average, 15%-25% of overall revenue can be retained by resolving accuracy issues in billing and coding operations.*

Important Trends for Revenue Integrity

MORE COSTLY DENIALS

Despite falling volumes of 33%+ in Q3 as compared to Q1 and Q2 of 2022, the average denial dollar value per claim increased across professional, outpatient hospital, and inpatient hospital billing by 2%, 6%, and 9.5%, respectively.

SLOWER PAYMENTS

The average lag days measured from billing to initial payer response also rose across professional, outpatient hospital, and inpatient hospital billing by 3 days, 4 days, and 6.5 days, respectively.

- **Move beyond your charge master.**
  To drive action that impacts denials and costs, adopt complementary workflow and analytics-oriented solutions outside of operational RCM and charge master systems. Operational systems are good at executing transactional tasks and actions, while analytical systems are beneficial for combing through large volumes of data and providing strategic insights.

  > *Organizations should invest in a hybrid architecture of operational and analytical systems to drive tangible outcomes.*

- **Audit with predictive intelligence.**
  Use predictive analytics and insights to take targeted action on errors before they impact revenue by deploying prospective audits on providers, coders, and facilities. Historical data integrated with real-time 3rd party market data can provide powerful predictive capabilities.

  > *Across the MDaudit cohort, prospective audits have increased by 31% in 2022 compared to 2021.*

- **Handle COVID-19 claims with care.**
  COVID-19 claims are a significant opportunity for health systems to prevent denials. Approximately $80M in COVID-19 charges failed audits across the MDaudit cohort, representing ~30% of the $260M total charges audited in professional and hospital billing.

  > *Avoiding denials for COVID-19 claims will save $50M in revenue impact for a mid-large sized health system in 2022.*

- **Collaborate with cross-functional teams.**
  Revenue integrity teams must work cross-functionally across the enterprise with compliance, HIM/coding, pharmacy, revenue cycle, and CDI counterparts to drive value.

  > *Leverage common data sources, technology platforms, and insight-sharing mechanisms to break down silos.*

Executive Insights for HIM/Coding

Compliance and coding leaders play a critical role to ensure that HIM and coding operations are audited and educated to mitigate compliance and revenue risk.

Based on MDaudit's analysis of unsatisfactory audit findings, the following areas offer the greatest opportunity for coding to help hospitals retain revenue.

- **Ensure secondary diagnosis is documented and billed.**
- **Correctly bundle and submit procedure codes together.**
- **Report drug unit utilization properly.**
- **Attach appropriate clinical documentation for diagnosis and treatment.**
- **Code and document modifiers properly.**
- **Confirm telehealth claims have correct information** – including place of service, duration, and payer responsible for the claim.
- **Leverage data-driven analytics to identify coder risk and implement targeted audits.**
  In addition to denied revenue, hospitals risk external payer audits for some billing and coding issues, placing an unnecessary and costly administrative burden on organizations.

Important Trends for HIM / Coding

MISSED REVENUE

22%

of professional billing coder audits resulted in unsatisfactory findings.

This translates to

19%

of missed revenue.

44%

of hospital billing coder audits resulted in unsatisfactory findings.

This translates to

25%

of missed revenue.

Background

> As a leading billing compliance and revenue integrity partner for the nation's premier healthcare organizations, MDaudit offers this in-depth analysis of benchmarks and insights derived from the more than 70,000 providers and 1,500+ facilities providing data to MDaudit for auditing and charge and denial analysis.

Our unparalleled user community offers the strength of shared insights and depth of data benchmarking to inform our thought leadership, and guide healthcare executives through the year ahead.

Demographic Overview

THE DATA CONTAINED IN THIS REPORT IS AGGREGATED FROM:

1,500+	70,000+	4,000+
FACILITIES	**PROVIDERS**	**CODERS**

900+	~$1.5B	$100B+
auditors and revenue integrity professionals	**of total charges audited in the MDaudit platform**	**of total charges denied by commercial and government payers**

ORGANIZATIONS INCLUDE:

Large health systems (IDNs) with more than $1B+ NPR	Regional hospitals	Academic research institutions	Large physician networks

LOCATION

All customers are U.S.-based and span coast to coast across 35 states.

PAYERS

Data includes charges and denials sent for both federal and commercial payers.

TIME PERIOD

Data was collected from the first three quarters of 2022.

Billing Compliance

Summary of Billing Compliance Insights

↑27%

Increase in auditing teams with more than 10 auditors

↑31%

Increase in prospective audits across professional and hospital billing

↑28%

Increase in risk-based audits across professional and hospital billing

$88

Compliance risk for incorrectly billing the professional claim – DRUG UTILIZATION

$2,122

Compliance risk for incorrectly billing a hospital claim – DRG

$242

Compliance risk for incorrectly billing a hospital claim – MODIFIER

$17

Compliance risk for incorrectly billing a professional claim – DIAGNOSES

34%

COVID-19 claims failed audit

$366

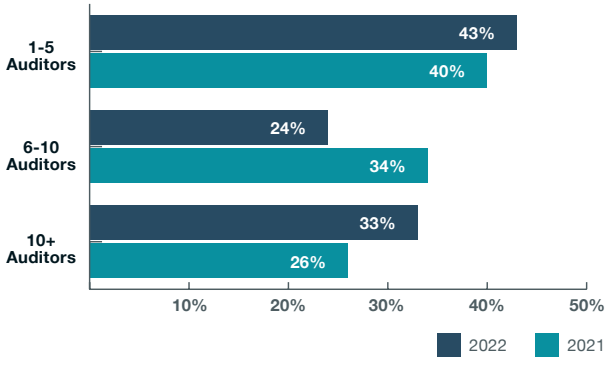
Revenue oppty. for correctly billing a hospital COVID-19-related claim

28%

Telehealth claims failed audit

Billing Compliance Benchmarks

- Compliance teams have expanded in size since 2021, demonstrating their increasing scope and importance as enterprise value drivers within healthcare organizations. Compliance teams having more than 10 auditors saw a 27% increase in 2022 compared to last year.
- Auditing teams have faced a plethora of strategic objectives in 2022 – a COVID-19 surge in the first half of the year, a boom in external audits from payers, and compliance and revenue risk in collaboration with cross-functional stakeholders in coding, revenue integrity, and CDI.
- Many of these teams are organized to perform various types of audits, including professional billing, hospital billing, revenue cycle, and coder audits.



WHAT ARE THEY AUDITING?	
Professional Billing Audits	**Hospital Billing Audits**
Diagnoses	Diagnoses
Diagnoses Position	DRG
CPT/HCPCS	Present on Admission (POA)
Date of Service	CPT/HCPCS
Place of Service	Drug Units
Modifiers	Modifiers

The Scope of Audits

The state of health billing compliance programs post-COVID has transformed for good.

- Teams are taking a more hybrid approach, using retrospective and prospective audits to proactively mitigate compliance and revenue issues before bills are sent to payers. 31% of all audits performed across professional, hospital, and coder entities this year were prospective audits. This is a significant 20%+ increase from last year's report.
- Due to the dynamic nature of emerging risks, compliance teams rely on real-time data and analytics across their ecosystems to proactively detect risks and perform risk-based audits to complement their annual compliance plan. There was a 28% increase in risk-based audits performed in 2022 compared to last year.
- Modifiers and telehealth are the top two areas for risk-based professional audits. In contrast, specialty drugs and PEPPER/OIG metrics continue to attract scrutiny in hospital billing as the top two at-risk areas.
- Specialty drugs drive a significant portion of Medicare healthcare costs. As CMS plans to negotiate drug pricing with pharmaceutical companies in the coming years, hospitals will continue to experience payer scrutiny for using branded specialty drugs vs. biosimilars, their utilization volumes, and administration site of care. The Congressional Budget Office (CBO) estimates a savings of ~$250B over 10 years following the availability of biosimilars.

TOP 5 TYPES OF AUDITS

The state of health billing compliance programs post-COVID has transformed for good.

	Professional Billing	Hospital Billing
1	Prospective Routine Audit	Monthly Facility Audit
2	New Provider	Coder Audit
3	Annual – Initial	Ad Hoc
4	Pre-Billing Review	Facility Coding
5	Monthly	Post Billing Audit

TYPES OF RISK-BASED AUDITS

	Professional Billing	Hospital Billing
1	Modifiers	Specialty Drugs
2	Telehealth	PEPPER/OIG Metrics
3	Injections	Surgeries
4	Department Risk	Durable Medical Equipment
5	E&M – Revenue Risk	Modifiers
6	Provider Risk	Labs

Audit Performance

MISSED REVENUE OPPORTUNITIES (UNDERCODING)

PROFESSIONAL BILLING AUDITS

31% of all audits performed were deemed unsatisfactory

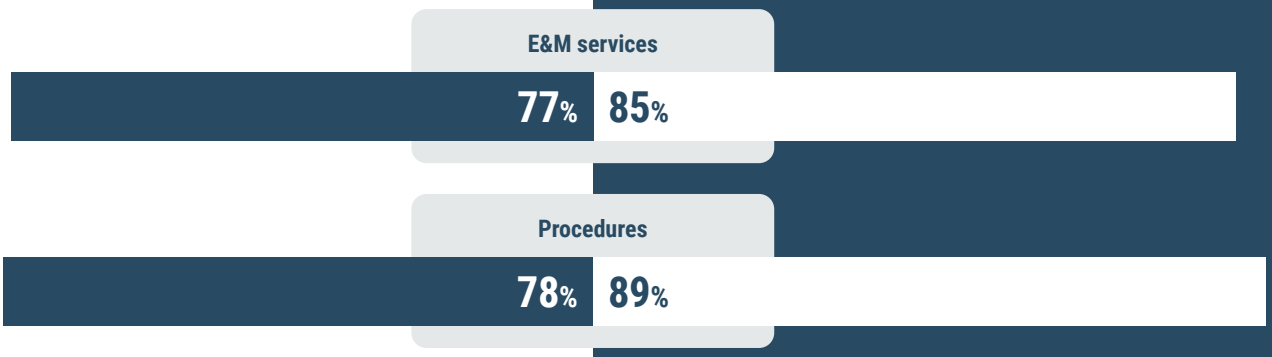
35% of rendering providers audited failed the audit

HOSPITAL BILLING AUDITS

18% of all audits performed were deemed unsatisfactory

25% of attending providers audited failed the audit

The overall case accuracy for:



Revenue opportunity per claim for billing correctly:

Drug Units =	$80
CPT/HCPCS =	~$24
Modifier =	~$17
Diagnoses =	~$8

Drug Units =	~$1,065
CPT/HCPCS =	~$432
Modifier =	~$423
Diagnoses =	~$670
DRG =	~$2,900

Significant revenue opportunities are available for healthcare organizations ensuring proper billing and coding of procedures, drug utilization, and modifiers on professional outpatient claims. For example, out of ~1M claims with an average 77% accuracy, 230K undercoded claims with the wrong CPT/HCPCS codes ($24 per claim) would result in ~$5.5M additional revenue.

Errors made in the billing and coding of hospital claims are more costly and offer a significant opportunity for organizations to get diagnoses, DRG, drug units, and procedures correct. For example, out of ~100K claims with an average 90% accuracy, 10k claims with missed DRG or wrong DRG codes ($2,900 per claim) would result in ~$29M additional revenue.

One MDaudit customer identified **$25M in underpaid revenue** by uncovering wrongly coded drug utilization for inpatient hospital cases at two of their facilities that allowed them to go back to the payer and retain those revenues.

COMPLIANCE RISK (OVERCODING OR UNNECESSARY CODES)

PROFESSIONAL BILLING AUDITS

HOSPITAL BILLING AUDITS

Compliance risk per claim:

	Professional	Hospital
Drug Units =	$88	~$172
CPT/HCPCS =	~$47	~$482
Modifier =	~$21	~$242
Diagnoses =	~$17	~$670
DRG =		~$2,122

Overcoding continues as an issue for professional billing, especially on E&M levels. Compliance teams should have a consistent playbook for auditing these claims, appealing denials to payers, and educating providers on mistakes. Commercial and federal payers have taken note of this E&M overcoding trend and are activating external audits to recover erroneous payments.

For patients who pay out-of-pocket, overcoding will drive them toward new provider organizations that bill and code properly as they seek to shop for affordable options. Enhanced patient experience is one benefit of improving billing and coding practices – patients lost represent revenue lost.

Undercoding AND overcoding present significant risks to the bottom line – especially in 2022, as profitability is a core concern for health systems.

AUDIT FAILURES

Professional Billing Audits

Top Reasons for Audit Failures

1	2	3	4	5
Diagnosis documented, but not billed	E&M service – overcoded 1 level	E&M service – undercoded 1 level	Diagnosis linked incorrectly	Diagnosis billed but not documented
(12%)	(12%)	(8%)	(3%)	(3%)

Top 5 codes on disagree audits

	1	2	3	4	5
Undercoding	99213	99203	99212	99232	99214
Overcoding	99214	99215	99233	99205	99212
Modifiers Required, Not Billed	GC	25	FS	59	93
Modifiers Billed, Not Needed	95	GC	26	25	CS

HOSPITAL BILLING AUDITS

Top Reasons for Audit Failures

1	2	3	4	5
Secondary diagnosis documented, but not billed	Diagnosis sequenced incorrectly	Additional information	Disagree – potential underpayment	Secondary diagnosis not supported by documentation
(8%)	(6%)	(5%)	(5%)	(5%)

Top 5 codes on disagree audits

	1	2	3	4	5
Undercoding	99284	J0585	99214	99285	99283
Overcoding	99284	99283	99213	99211	99212

COVID-19 Claims Audits

PROFESSIONAL BILLING AUDITS

34%
of all COVID-19 cases audited were unsatisfactory

$10
Revenue opportunity per claim (undercoded)

$25
Compliance risk identified per claim (overcoded)

HOSPITAL BILLING AUDITS

23%
of all COVID-19 cases audited were unsatisfactory

$366
Revenue opportunity per claim (undercoded)

$1,272
Compliance risk identified per claim (overcoded)

Top Reasons for Audit Failures

E&M service overcoded level 1	(11%)	1	Secondary diagnosis documented, but not billed	(7%)
Diagnosis documented, but not billed	(10%)	2	Primary diagnosis not supported by documentation	(5%)
Undercoded E&M	(5%)	3	Additional information needed	(5%)
Diagnosis billed, but not documented	(4%)	4	Medical necessity not supported by documentation	(3%)
Modifier required, but not billed	(4%)	5	Incorrect POA/procedure date	(3%)

Approximately $80M in COVID-19 charges failed audits across the MDaudit cohort, representing ~30% of the $260M total charges audited in professional and hospital billing. Auditing COVID-19 charges is a significant opportunity for health systems to prevent denials.

COVID-19 TRENDS

- The majority of COVID-19 cases audited this year were professional office and outpatient hospital visits, as the availability of therapeutics, vaccines, and testing resulted in lower inpatient hospital volume compared to 2021.
- Most of the COVID-19 hospital outpatient claims that failed audits were for patients with comorbidities that were not represented with proper billing and coding protocols, including CC/MCC cases.

Telehealth Claims Audits

PROFESSIONAL BILLING AUDITS

28%

of all telehealth cases audited were unsatisfactory

Top Reasons for Audit Failures

1	2	3	4	5
Incorrect E&M category	Modifier required, but not billed	E&M Service Overcoded 1 Level	Insufficient documentation for E&M	Not Billable
(12%)	(7%)	(6%)	(5%)	(5%)

TELEHEALTH CLAIMS AUDITS – TRENDS

- Telehealth audit failures in 2022 are driven by modifiers and overcoded claims – either missing modifiers, unnecessary modifiers or overcoded claims.
- Overall telehealth volumes fell in 2022 as patients returned to in-person office visits.

Revenue Integrity

REVENUE CYCLE
- Are the bills going out at the right time/right place/ right payer?
- Are we paid on time/why are claims denied?

BILLING COMPLIANCE
- Are proper billing/coding rules being followed?
- Is there proper medical documentation?

PATIENT EXPERIENCE
- Am I paying the right amount for high-quality care and experience?
- How much do I owe out-of-pocket?

BILLING OPS
- Is all the information on the bill correct?
- Have we captured all the charges?
- Are there billing errors?

CODING
- Are the coders coding properly?
- Are we aware of recent regulatory updates?

CLINICAL/IT
- Am I documenting encounters properly?
- Are the billing edits in the system correct?
- Are my code scrubbers applying the correct rules?

Different stakeholders are asking different questions from the same data

ORGANIZATIONS SUCCESSFULLY DRIVING OUTCOMES WITH REVENUE INTEGRITY ARE:

Breaking down silos and working across the aisle with other functional teams – including compliance, coding, RCM, and clinical – to drive a unified revenue retention and growth agenda.

Setting up a formal revenue integrity program and a steering committee of cross-functional leaders to meet and share insights on a regular cadence.

Leveraging data and insights as a storytelling mechanism to deliver value by removing bias and injecting objectivity into discussions and decision-making.

Defining success metrics and leveraging powerful technology to boost team productivity, streamline manual processes, and establish accountability for tangible outcomes.

Keeping an open mind to learn from other organizations and peers about best practices to drive outcomes.

Summary of Revenue Integrity Insights

↑2%
Increase in avg. denial value for professional claims vs. 2021

↑6%
Increase in avg. denial value for hospital outpatient claims vs. 2021

↑9.6%
Increase in avg. denial value for hospital inpatient claims vs. 2021

↑3 lag days
Increase in avg. lag days for professional claims (payer response) vs. 2021

↑4 lag days
Increase in avg. lag days for hospital outpatient (payer response) vs. 2021

↑6.5 lag days
Increase in avg. lag days for hospital inpatient (payer response) vs. 2021

↓24%
Decrease in professional denial volumes in Q3 22 vs. Q3 21 primarily driven by low patient volumes

↓33%
Decrease in hospital inpatient denial volumes in Q3 22 vs. Q3 21 primarily driven by low patient volumes

↓31%
Decrease in hospital outpatient denial volumes in Q3 22 vs. Q3 21 primarily driven by low patient volumes

$9,180
Average denial value of a COVID-19 inpatient claim

$366
Revenue oppty. for correctly coding a hospital-related COVID-19 claim

$280
Average denial value of a telehealth claim

BUNDLING
Top denial reason for inpatient and outpatient hospital claims

CLAIM SUBMISSION / BILLING ERRORS
Top denial reason for professional claims

82%
Claims initially denied by Medicare since the start of the year

$80
Revenue oppty. for correctly billing a professional claim – Drug Utilization

$17
Revenue oppty. for correctly billing a professional claim – Modifier

$24
Revenue oppty. for correctly billing a professional claim – CPT/HCPCS

$670
Revenue oppty. for correctly billing a hospital claim – Diagnoses

$432
Revenue oppty. for correctly billing a hospital claim – CPT/HCPCS

$1,065
Revenue oppty. for correctly billing a hospital claim – Drug Utilization

$2,900
Revenue oppty. for correctly billing a hospital claim – DRG

$366
Revenue oppty. for correctly billing a hospital-related claim – COVID-19

$423
Revenue oppty. for correctly billing a hospital claim – Modifier

Denials

As provider organizations experience simultaneous demand pressures in declining patient visits and supply pressures in labor and supply costs, healthcare may be ushering in a new phenomenon in which spending becomes discretionary for consumers impacted by inflation.

In this era, the margin of error is minimal for organizations to get billing, coding, and revenue cycle processes correct.

DENIALS: PROFESSIONAL CLAIMS

TRENDS IN PROFESSIONAL CLAIMS DENIALS

12% of the total professional charges submitted to payers in 2022 were initially rejected.

- The average professional charge amount denied by payers in 2022 was $288, a 2% increase from 2021. When this increase in denials is applied to millions of patient visits, it translates to a substantial amount of lost revenue.
- Average lag days in 2022– the time from professional claim submission to initial payer response – was 13 days, a 3-day increase from 2021. Slower payer response is adding pressure to operational teams to ensure claims are billed correctly on the first pass.
- For the first half of 2022, denied professional count volumes were almost flat relative to the same period in 2021. For Q3, however, denied count volumes fell by 24% as compared to 2021. Declining denial count volumes reflect a larger trend of softening healthcare demand.

Top Reasons for Denials

1	2	3	4	5	6
Claim submission and billing errors	Duplicate claims issue	Documentation is required to adjudicate this claim	Bundling related issues	Pre-certification/ authorization	Non-covered charges
(10%)	(10%)	(9%)	(8%)	(6%)	(5%)

Top 10 Principal Diagnosis Codes Denied

Principal Diagnosis Code	Principal Diagnosis Name
Z00.00	Encounter For General Adult Medical Exam W/O Abnormal Findings
Z00.129	Encounter For Routine Child Health Exam W/O Abnormal Findings
U07.1	COVID-19
I10	Essential (Primary) Hypertension
Z51.11	Encounter For Antineoplastic Chemotherapy
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris
F11.20	Opioid Dependence, Uncomplicated
J96.01	Acute Respiratory Failure with Hypoxia
N18.6	End Stage Renal Disease
C61	Malignant Neoplasm of Prostate

Top 10 CPT Codes Denied

CPT Code	Name
99214	Office O/P Est Mod 30-39 Min
99213	Office O/P Est Low 20-29 Min
99233	Subsequent Hospital Care
99291	Critical Care First Hour
99204	Office O/P New Mod 45-59 Min
99232	Subsequent Hospital Care
99215	Office O/P Est Hi 40-54 Min
99223	Initial Hospital Care
99203	Office O/P New Low 30-44 Min
99285	Emergency Dept Visit

DENIALS: HOSPITAL OUTPATIENT

TRENDS IN HOSPITAL OUTPATIENT CLAIMS DENIALS

26% of the total hospital outpatient charges submitted to payers in 2022 were initially rejected.

- 62% of the denials related to hospital outpatient cases in 2022 were bundling related denials.
- The average hospital outpatient charge amount denied by payers in 2022 was $602, a 6% increase from 2021. When this increase in denials is applied to millions of outpatient visits, it translates to a substantial amount of lost revenue.
- Average lag days in 2022 – the time from hospital outpatient claim submission to initial payer response – was 15 days, a 4-day increase from 2021. Slower payer responses are adding pressure on operational teams to ensure claims are billed correctly on the first pass.
- For the first half of 2022, hospital outpatient denied count volumes were up by 17% when compared to the same period in 2021. For Q3, however, denied count volumes fell by 31% as compared to 2021. Declining denial count volumes reflect a larger trend of softening healthcare demand.

Top Reasons for Hospital Outpatient Denials

1	2	3	4	5
Bundling-related issues	Pre-Certification/ Authorization	Claim submission/billing errors	Documentation is required to adjudicate this claim	Non-covered charges
(62%)	(4%)	(4%)	(2%)	(1%)

Top 10 Principal Diagnosis Codes Denied

Principal Diagnosis Code	Principal Diagnosis Name
Z00.00	Encounter For General Adult Medical Exam W/O Abnormal Findings
Z00.129	Encounter For Routine Child Health Exam W/O Abnormal Findings
U07.1	COVID-19
I10	Essential (Primary) Hypertension
Z51.11	Encounter For Antineoplastic Chemotherapy
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris
F11.20	Opioid Dependence, Uncomplicated
J96.01	Acute Respiratory Failure with Hypoxia
N18.6	End Stage Renal Disease
C61	Malignant Neoplasm of Prostate

Top 10 CPT Codes Denied

CPT Code	Name
99214	Office O/P Est Mod 30-39 Min
99213	Office O/P Est Low 20-29 Min
99233	Subsequent Hospital Care
99291	Critical Care First Hour
99204	Office O/P New Mod 45-59 Min
99232	Subsequent Hospital Care
99215	Office O/P Est Hi 40-54 Min
99223	Initial Hospital Care
99203	Office O/P New Low 30-44 Min
99285	Emergency Dept Visit

Top 10 Hospital Outpatient Principal Diagnosis Codes Denied

Principal Diagnosis Code	Principal Diagnosis Name
Z51.11	Encounter For Antineoplastic Chemotherapy
M17.11	Unilateral Primary Osteoarthritis, Right Knee
I48.0	Paroxysmal Atrial Fibrillation
Z51.0	Encounter For Antineoplastic Radiation Therapy
M17.12	Unilateral Primary Osteoarthritis, Left Knee
I25.10	Athscl Heart Disease of Native Coronary Artery W/O Ang Pctrs
Z12.11	Encounter For Screening for Malignant Neoplasm Of Colon
U07.1	COVID-19
R07.89	Other Chest Pain
R07.9	Chest Pain, Unspecified

Top 10 Hospital Outpatient Procedure Codes Denied

HCPCS Procedure Code	HCPCS Procedure Name
G0378	Hospital Observation Service Per Hour
C1776	Joint Device
74177	CT ABD & Pelv W/Contrast
99285	Emergency Dept Visit
80053	Comprehensive Metabolic Panel
C1713	Anchr/Screw Oppos BN-BN/SFT TISS-BN
93005	Electrocardiogram Tracing
99284	Emergency Dept Visit
85025	Complete CBC W/Auto Diff WBC
70450	CT Head/Brain W/O Dye

DENIALS: HOSPITAL INPATIENT

TRENDS IN HOSPITAL INPATIENT CLAIMS DENIALS

27% of the total hospital inpatient charges submitted to payers in 2022 were initially rejected.

- 34% of the denials related to hospital outpatient cases in 2022 were bundling related denials.
- The average hospital inpatient charge amount denied by payers in 2022 was $5,810, a 9.5% increase from 2021. When this increase in denials is applied to millions of inpatient visits, it translates to a substantial amount of lost revenue.
- Average lag days – the time from hospital inpatient claim submission to initial payer response – was 16.5 days, a 6.5-day increase from 2021. Slower payer response is adding pressure to operational teams to ensure claims are correct on the first pass.
- For the first half of 2022, hospital inpatient denied count volumes were almost flat relative to the same period in 2021. For Q3, however, denied count volumes fell by 33% as compared to 2021. Declining denial count volumes reflect a larger trend of softening healthcare demand.

Top Reasons for Hospital Inpatient Denials

1	2	3	4	5
Bundling-related issues	Charges are covered under a capitation agreement/managed plan	Documentation is required to adjudicate this claim	Billing and Claim Submission error	Duplicate Claims
(34%)	(14%)	(6%)	(6%)	(4%)

Top 10 Hospital Inpatient DRG Codes Denied

DRG Code	DRG Name
871	Septicemia Or Severe Sepsis Without Mv >96 Hours with Mcc
003	Ecmo Or Tracheostomy with Mv >96 Hours Or Principal Diagnosis Except Face, Mouth And Neck With Major O.R. Procedures
177	Respiratory Infections and Inflammations with Mcc
853	Infectious and Parasitic Diseases with O.R. Procedures With Mcc
004	Tracheostomy With Mv >96 Hours or Principal Diagnosis Except Face, Mouth And Neck Without Major O.R. Procedures
291	Heart Failure and Shock With Mcc
870	Septicemia Or Severe Sepsis with Mv >96 Hours
207	Respiratory System Diagnosis with Ventilator Support >96 Hours
790	Extreme Immaturity or Respiratory Distress Syndrome, Neonate
885	Psychoses

Top 10 Hospital Inpatient Procedure Codes Denied

HCPCS Procedure Code	HCPCS Procedure Name
97810	Acupunct W/O Stimul 15 Min
C1776	Joint Device
C1713	Anchr/Screw Oppos BN-BN/SFT TISS-BN
99199	Special Service/Proc/Report
93005	Electrocardiogram Tracing
Q2042	CTIL019 To 600 M CAR-+ VI T CE P TD
Q2055	Idecabtagene Vicleucel Car
74177	CT Abd and Pelv W/Contrast
80053	Comprehen Metabolic Panel
P9045	Infusion Albumin Human 5% 250 Ml

Top 10 Hospital Inpatient Diagnosis Codes Denied

Principal Diagnosis Code	Principal Diagnosis Name
A41.9	Sepsis, Unspecified Organism
U07.1	COVID-19
Z38.01	Single Liveborn Infant, Delivered by Cesarean
A41.89	Other Specified Sepsis
I21.4	Non-St Elevation (Nstemi) Myocardial Infarction
Z38.00	Single Liveborn Infant, Delivered Vaginally
I13.0	Hyp Hrt & Chr Kdny Dis W Hrt Fail and Stg 1-4/ Unsp Chr Kdny
I11.0	Hypertensive Heart Disease with Heart Failure
N17.9	Acute Kidney Failure, Unspecified
A41.51	Sepsis Due to Escherichia Coli [E. Coli]

Top 10 Hospital Inpatient HCC Codes Denied

HCPCS Procedure Code	HCPCS Procedure Name
2	Septicemia, Sepsis, SIRS/Shock
85	Congestive Heart Failure
86	Acute Myocardial Infarction
176	Complications of Specified Implanted Device or Graft
100	Ischemic or Unspecified Stroke
84	Cardio-Respiratory Failure and Shock
170	Hip Fracture/Dislocation
96	Specified Heart Arrhythmias
8	Metastatic Cancer and Acute Leukemia
18	Diabetes with Chronic Complications

DENIALS: COVID-19

Across professional and hospital billing, 28% of COVID-19 charges were rejected by payers in 2022. When we analyzed our medium-to-large customers with more than $500M+ in net patient revenue, avoiding COVID-19 denials across professional and hospital inpatient and outpatient segments represented a ~$50M revenue opportunity.

TRENDS IN COVID-19 CLAIMS DENIALS

Total COVID-19 charges rejected by payers in 2022

10%	27%	30%
Professional	Hospital Outpatient	Hospital Inpatient

Average COVID-19 claim charge amount denied by payers in 2022

$238	$394	$9,180
Professional 4% decrease from 2021	Hospital Outpatient 10% increase over 2021	Hospital Inpatient 3% increase over 2021

Average lag days – the time from COVID-19 claim submission to initial payer response in 2022

16 days	18 days	31 days
Professional 2-day increase over 2021	Hospital Outpatient 2-day increase over 2021	Hospital Inpatient 4-day increase over 2021

COVID-19 patient volume in 2022, compared to 2021

↑ 10%	↑ 12%	↓ 20%
Professional	Hospital Outpatient	Hospital Inpatient

Top Reasons for Professional COVID-19 Denials

1	2	3	4	5
Claim submission/billing errors	Duplicate claims	Bundling related	Covered by another payer per coordination of benefits (COB)	Non-timely filing
(11%)	(10%)	(6%)	(6%)	(5%)

Top Reasons for Hospital Outpatient COVID-19 Denials

1	2	3	4	5
Bundling related	Claim submission/billing errors	Non-covered charges	Covered by another payer per COB	Documentation is required to adjudicate this claim
(63%)	(5%)	(3%)	(2%)	(2%)

Top Reasons for Hospital Inpatient COVID-19 Denials

1	2	3	4	5
Bundling related	Charges are covered under a capitation agreement/managed plan	Documentation is required as evidence	Claim submission/billing errors	Duplicate claim
(29%)	(15%)	(9%)	(7%)	(6%)

DENIALS: TELEHEALTH DENIALS

TRENDS IN TELEHEALTH CLAIMS DENIALS

10% of the total telehealth charges submitted to payers in 2022 were initially rejected.

- The average telehealth charge amount denied by payers in 2022 was $280, a 2% increase from 2021.
- Average lag days in 2022 – the time from telehealth claim submission to initial payer response – was 12 days, a 2-day increase from 2021. Slower payer response is adding pressure to operational teams to ensure claims are correct on the first pass.
- Telehealth denied count volumes fell by 21% relative to 2021 as more patients are using telehealth as a part of a hybrid mode of care, along with in-person office visits in 2022 relative to 2021.

Top Reasons for Telehealth Denials

1	2	3	4	5
Charges are covered under a capitation agreement/managed plan	Claim submission/billing errors	Duplicate claims	Non-covered charges	Pre-certification/ authorization
(11%)	(10%)	(7%)	(7%)	(5%)

Payer Trends

A staggering 82% of the initial claims denials this year were rejected by Medicare Part A and Part B payers.

- Starting in Jan. 2022, this number was 62% and rose 20% in the next 9 months.
- More than 98% of those claims were hospital outpatient.

Top Reasons for Medicare-Related Professional Claims

- Bundling
- Non-covered charges
- Billing and claim submission errors
- Place of service – office visit/inpatient hospital/outpatient hospital/ER - hospital

Top Reasons for Medicare-Related Hospital Outpatient Claims

- Bundling
- Non-covered charges
- Medical necessity

Top Revenue Areas Targeted by Medicare Denials

- Laboratory – chemistry, general classification, hematology, immunology, bacterial, and microbiology

Based on MDaudit analysis of denials from the top 20 payers across a cohort of our largest 60 customers.

HIM/Coding

Summary of Coding Insights

22%
Professional coders who failed audits

44%
Hospital coders who failed audits

19%
Missed revenue opportunity due to incorrect professional coding

25%
Missed revenue opportunity due to incorrect hospital coding

32%
Professional claims denied due to missing or incorrect modifiers

34%
Hospital claims denied due to missing or incorrect modifiers

$5,720
Average denial value of an inpatient claim due to incorrect coding

$672
Average denial value of a hospital outpatient claim due to incorrect coding

$236
Average denial value of a professional claim due to incorrect coding

$11,200
Average denial value of an inpatient COVID-19 claim due to incorrect coding

$193
Average denied amount of a telehealth claim due to incorrect coding

Coding Audits

Leaders have a critical role to play in ensuring HIM and coding operations are audited and educated to mitigate compliance and revenue risk. In addition to denied revenue, hospitals risk audits from external payers for billing and coding issues, placing a costly and unnecessary administrative burden on organizations with already limited staff resources.

UNSATISFACTORY CODER AUDIT FINDINGS

22%
19% of missed revenue
professional billing coders

44%
25% of missed revenue
hospital billing coders

Out of $1B in billed claims, hospitals can retain approximately $150M - $250M by ensuring accurate coding and billing protocols.

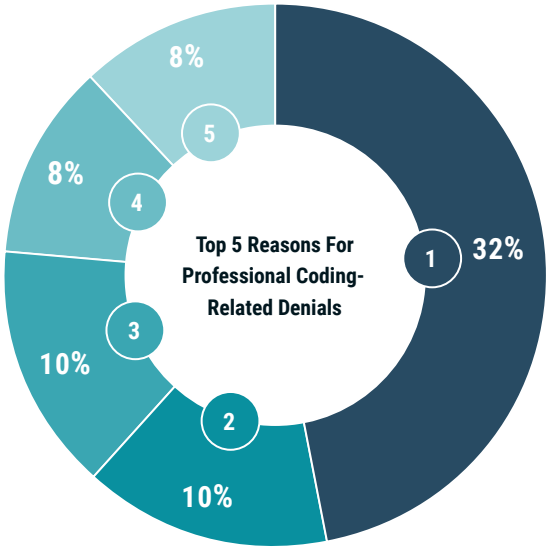
As hospitals face unprecedented profitability concerns this year, coding teams have a crucial role in helping hospitals retain millions of dollars in revenue.

Based on MDaudit's analysis of unsatisfactory audit findings, the following areas offer the greatest opportunity for coding to help hospitals retain revenue.

- Ensure secondary diagnosis is documented and billed
- Bundle and submit procedure codes appropriately
- Report drug unit utilization properly
- Attach clinical documentation for diagnosis and treatment
- Ensure proper modifiers are coded with documentation

Coding-Related Denials

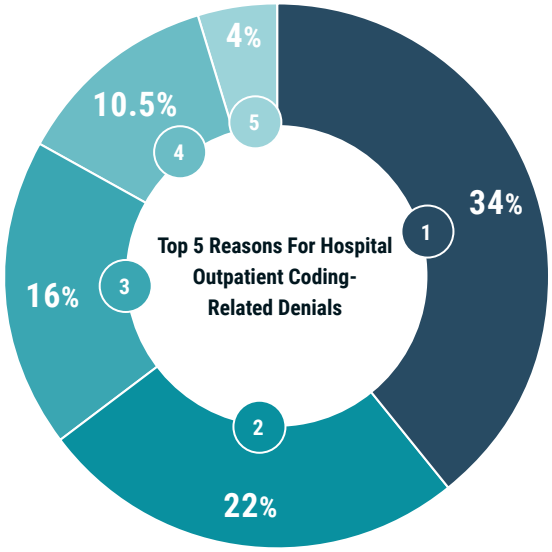
PROFESSIONAL



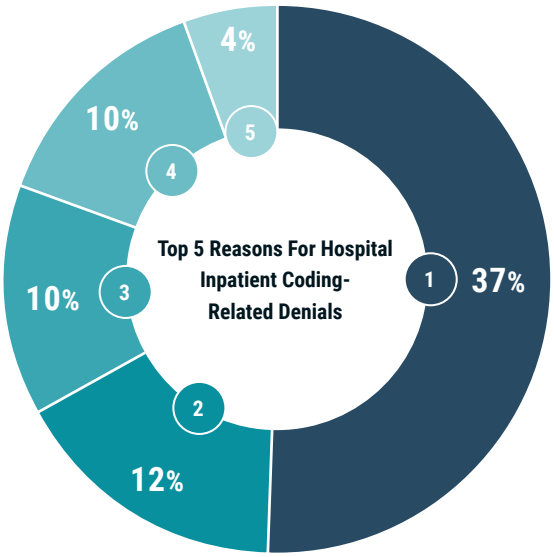
1. Missing modifier or inconsistent modifier with the procedure code
2. Diagnosis is inconsistent with the procedure
3. Procedure code/type of bill inconsistent with place of service
4. New patient qualifications were not met
5. Multiple physicians/assistants are not covered in this case

HOSPITAL OUTPATIENT

1. Missing modifier or modifier is inconsistent with the procedure code
2. Charge does not meet qualifications for emergency/urgent care
3. Diagnosis is inconsistent with the procedure
4. Payer does not deem the information submitted supports the level of service
5. Diagnosis is not covered



HOSPITAL INPATIENT



1. Payer does not deem the information submitted supports the level of service
2. The date of death precedes the date of service
3. Diagnosis is inconsistent with the procedure
4. Invalid or inappropriate place of service
5. Diagnosis is not covered

KEY CODING DENIAL STATS

Average coding-related denied amount in 2022

$236	$672	$5,720
Professional	Hospital Outpatient	Hospital Inpatient

Average coding-related COVID-19 claim charge amount denied by payers in 2022

$191	$544	$11,200
Professional	Hospital Outpatient	Hospital Inpatient

CMS Integrity Programs – FY 2023

WHY THE INVESTMENT?

- Together CMS, DOJ, and OIG will invest in innovative program integrity tools to fight fraud, waste, and abuse in a changing healthcare landscape.*
- New advancements in predictive modeling and artificial intelligence will allow CMS to enhance existing efforts to reduce improper payments, prevent fraud, and target bad actors without additional administrative burden. For example, CMS is exploring methods of using machine learning to conduct a more rapid review of chart documentation to improve payment accuracy.*
- CMS will also increase data analytics and improper payment measurement for the marketplace.
- This additional investment is projected to total $6.6B over the 10-year budget window and yield $13.6B in Medicare and Medicaid baseline savings, returning more than double the investment.
- Medicare Integrity Program activities, inclusive of medical review, yield a robust rate of return to the trust funds of over $8 for every $1 spent based on a three-year rolling average.

* U.S. Department of Health & Human Services Fiscal Year 2023 Budget in Brief

Looking Ahead

UNDERSTAND THE ENVIRONMENT

As the macroeconomic environment gets tougher, health systems have a real challenge to protect and grow revenue streams in the months and years ahead. Against this landscape, revenue integrity, billing compliance, coding, and revenue cycle teams must work together cross-functionally in breaking down silos to protect hospital revenues. The importance of coding correctly and submitting accurate claims will continue to grow as systems outsource capabilities and use personnel from external agencies. Our analysis concludes that organizations can retain approximately 15%-25% of their revenue by ensuring accurate billing and coding protocols.

On the regulatory front, the HHS budget offers a clear indicator that Medicare and Medicaid will increasingly utilize AI and machine learning to analyze and adjudicate claims. Revenue retention will be as critical as revenue growth heading into 2023.

Changes in commercial payers' claim review strategies and increased use of AI are contributing to slower payments and increased denials. Traditionally, payers were likely to pay claims first and audit later, but going forward, AI and machine learning will enable them to analyze large volumes of claims rapidly, resulting in more scrutiny prior to paying any claim that may be an anomaly.

MAKE THE RIGHT INVESTMENTS TO DRIVE RESULTS

Effective compliance and revenue integrity workflows require the right technology, subject matter expertise, and collaboration and communication among departments. Teams can leverage powerful technologies and data to identify, prioritize, and address systemic compliance and denial risks with the most significant financial impact, maximizing precious resources where they are needed most.

As payers become more sophisticated with advanced analytics and technologies, hospitals and health systems must respond in kind to optimize revenue. Health systems should capitalize on investments in automation, AI, data, and technology platforms to enable productive, cost-efficient teams that drive targeted business goals.

Business and IT leaders should champion technology-driven initiatives in which agility, business outcomes, and change management are prioritized over traditional approaches with multi-year technology selection and implementations, staffing large teams to do manual and unproductive work.

About MDaudit

Powered by sophisticated analytics and augmented intelligence, MDaudit enables organizations to reduce compliance risk, improve efficiency, and retain more revenue by providing workflow automation, risk monitoring, and built-in analytics and benchmarking capabilities – all in a single, integrated, cloud-based platform.

To learn more, visit **www.mdaudit.com**